Annual Report
Medicaid and CHIP Quality-Based Initiatives
and
Recommendations by the Medicaid and CHIP Quality-Based Payment Advisory Committee

As Required By
S.B. 7, 82nd Legislature,
First Called Session, 2011

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Annual Report of the Medicaid and CHIP Quality-Based Initiatives and Recommendations by the Medicaid and CHIP Quality-Based Payment Advisory Committee

Executive Summary

S.B. 7, 82nd Legislature, First Called Session, 2011, requires the Health and Human Services Commission **(**HHSC) to submit an annual report to the legislature regarding quality-based outcome and process measures, to include the progress on the implementation of quality-based payment systems and other payment initiatives.

S.B. 7 also established the Medicaid and Children's Health Insurance Program (CHIP) Quality-Based Payment Advisory Committee (QBPAC) to advise HHSC on establishing reimbursement policies and systems that reward high quality and cost-effective care, and to advise HHSC on outcome and process measures, and standards and benchmarks used to measure performance.

Accordingly, this annual report provides the following:

- an update on the progress and implementation of quality-based payment systems initiatives;
- other key HHSC quality related initiatives
- recommendations from the Quality-Based Payment Advisory Committee (QBPAC); and
- an outline for a potential strategic path for HHSC regarding quality and efficiency pursuant to legislation passed by the 83rd Legislature.

Legislation

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S.B. 7 also established the Medicaid and Children's Health Insurance Program (CHIP) Quality-Based Payment Advisory Committee (QBPAC) to advise HHSC on establishing reimbursement policies and systems that reward high quality and cost-effective care by managed care organizations, physicians and other health care providers. In addition, the committee advises HHSC on outcome and process measures, and standards and benchmarks used to measure performance.

Progress of Quality-Based Payment Systems Initiatives

HHSC has made significant strides in its approach to quality since the inception of managed care. With the continued shift of Medicaid away from the traditional fee-for-service model, HHSC has focused on ensuring an effective, comprehensive quality strategy within the managed care organization (MCO) contracting model. Elements of this overall quality strategy are also reflected in many provisions of S.B. 7 that was enacted in 2011, and in S.B. 7 that was enacted in 2013. Some of the directives in these bills include the following:

- explore alternate MCO capitation methodologies to promote provider payment reform and efficiency;
- create effective financial incentives and disincentives to positively influence MCO and provider innovation, quality and efficiency using appropriate outcome and process measures, including measures based on potentially preventable events (PPEs). This includes two main components;
  - MCO capitation that is at-risk, based on select quality measures
  - MCO payment structures/incentives with providers
- provide enrollees with quality-related information about MCO performance to aid in the selection process;
- study ways to expedite the enrollment process into MCOs;
- create an auto-enrollment program that enrolls a greater percentage of default enrollments into MCOs that have high quality and/or efficiency;
- develop robust internal and contracted analytical resources to effectively and continuously measure performance;
- require MCO collaboration on quality-based performance improvement projects where possible, based on the needs of community;
- focus more on high-value outcome measures instead of process measures, to include PPEs;
- promote performance transparency and public reporting; and
- remove administrative barriers/burdens, where possible.

HHSC continues to refine the standards, benchmarks and metrics used to measure quality, as well as to develop the necessary MCO contract provisions, policies and reimbursement systems that reward the provision of high-quality, cost-effective health care. These efforts are conducted in close consultation with the Medicaid and CHIP QBPAC, as well as Texas' Medicaid/CHIP External Quality Review Organization (EQRO), the Institute for Child Health Policy-University of Florida (ICHP).

Outcome and Process Measures, Standards and Benchmarks in Medicaid/CHIP

Historically, the Medicaid Fee for Service model in Texas did not have well developed processes to track outcome and process quality measures. With the advent of the MCO model, HHSC is able to better leverage numerous outcome and process quality measures for acute care Medicaid and CHIP programs. The analysis and tracking for these measures are done by the HHSC's contracted Medicaid/CHIP EQRO. Measures used by

HHSC include the following national and state level process and outcome measures of healthcare quality:

- Healthcare Effectiveness Data and Information Set (HEDIS)
- Agency for Healthcare Research and Quality (AHRQ) measures
- Other measures endorsed by National Quality Forum (NQF)
- Hybrid measures that utilize data from provider claims coupled with medical records reviews
- HEDIS Relative Resource Use (RRU) measures (future measures)
- Potentially Preventable Events
- Enrollee Perception of Care
- Provider Network Adequacy
- Enrollee Complaints/appeals
- Emerging Data from Electronic Health Records
- Relative Resource Use Measures (cost-quality)
- Quality Assessment and Performance Improvement Tool (QAPI)
- MCO Administrator Interviews and Surveys
- Assessment of Member Experiences with their Medical Home

The full list of quality measures used by HHSC can be found in Appendix A.

Standards and Benchmarks Used By HHSC to Measure MCOs

Standards and benchmarks for the quality measures are determined using the following standards:

- Healthcare Effectiveness Data and Information Set (HEDIS) standards
- HEDIS-"like" standards (similar to HEDIS, but certain HEDIS specifications relaxed)
- Agency for Healthcare Research and Quality (AHRQ) standards
- Risk-adjusted methodologies related to potentially preventable events
- Other HHSC-developed standards

Key HHSC Quality Related Initiatives

HHSC is involved in many key activities that are designed to improve quality. The projects listed below were initiated in the last two years and are currently being implemented and/or evaluated.

Medicaid Pre-39 Weeks Elective Induction Policy: H.B 1983, 82nd Legislature, Regular Session, 2011

H.B. 1983 directed HHSC to achieve cost savings with improved outcomes by adopting and implementing evidence-based quality initiatives designed to reduce the number of elective or non-medically indicated induced deliveries or cesarean sections performed at

a hospital on a medical assistance recipient before the 39th week of gestation. Pursuant to this direction, HHSC implemented a Medicaid policy of nonpayment for elective induction prior to 39 weeks of gestation, if medical indication was not supported by medical documentation. An outreach and education effort was conducted by HHSC with the provider and stakeholder community prior to implementation of the policy on October 1, 2011. Close monitoring and evaluation of the utilization trends, quality metrics and cost savings continue post-implementation.

It would be premature to provide an estimate of savings attributed to pre-39 weeks elective induction policy implementation at this time. While the post-implementation trend for Average Length of Stays for Neonatal Intensive Care Units is encouraging, there is not enough post implementation data to support a rough savings estimate. HHSC Strategic Decision Support (SDS) will continue to analyze the impact of the policy, as more data become available. External studies also will be conducted to evaluate the impact of this policy.

Potentially Preventable Events (PPEs)

HHSC has begun to focus on potentially preventable events as key healthcare outcome measures, which may encompass quality issues such as access to care, coordination of care, and quality of care. This effort began in January 2011, with reporting of Potentially Preventable Re-admissions (PPRs) to hospitals for fee-for-service and managed care populations. In February 2012, the EQRO began reporting rates and costs associated with Potentially Preventable Admissions (PPAs), PPRs, and Potentially Preventable Emergency Room Visit (PPVs) to the STAR, STAR+PLUS and CHIP managed care organizations. This effort has begun to expand to include Potentially Preventable Complications (PPCs). Potentially Preventable Ancillary Services (PPSs) will likely be a future measure, but more development is needed.

HHSC has started to use performance data related to PPEs to promote quality and efficiency within the Medicaid/CHIP programs. In Fee for Service Medicaid, hospital payment adjustments based on rates of PPRs were implemented in May 2013. HHSC is scheduled to implement similar hospital payment adjustments for PPC later in 2013. Similar adjustments to MCO capitation rates will be implemented in FY14. Beginning in calendar year 2014, PPVs, PPAs, and PPRs will also be utilized in the MCO incentive/disincentive (capitation at-risk) program.

Medicaid Transformation Waiver

In December 2011, Texas received federal approval of a Medicaid 1115(a) waiver that would preserve Upper Payment Limit (UPL) funding under a new methodology, while allowing for managed care expansion in additional areas of the state. Under this waiver (called the Medicaid Transformation Waiver), supplemental payment funding, managed care savings, and negotiated funding will go into two statewide pools now estimated at $29 billion (all funds) over five years.

1. An uncompensated care (UC) pool to reimburse for uncompensated care costs as reported in the annual waiver application/UC cost report.

2. A Delivery System Reform Incentive Payment (DSRIP) pool to incentivize hospitals and other providers to transform their service delivery practices to improve quality, health status, patient experience, coordination, and cost-effectiveness.

The 20 Regional Healthcare Partnerships (RHPs) formed as a result of the waiver have sought DSRIP funding for more than 1,300 quality improvement projects. Many of these projects align with overall goals of the MCO quality strategy. The impacts of the RHP projects vis-a-vis MCO strategy will be evaluated as data become available.

State Innovation Models Initiative

The federal Centers for Medicare & Medicaid Services (CMS) granted HHSC a model design award as part of the State Innovation Models Initiative. Under this project, Texas is designing innovative multi-payer delivery and payment models that base payment on quality outcomes rather than the traditional fee-for-service system. Potential models include Accountable Care Organizations, shared savings arrangements, bundled payments, or medical/health homes.

To design innovative payment and delivery models, HHSC is:

- convening public and private payers, providers and other stakeholders to develop a consensus around the design of innovative models and to determine the elements needed to successfully implement such models;
- researching actuarial and financial models and determining policy options; and
- planning meaningful, sustainable models specific to meeting the needs of Texans.

Adult Quality Measures Grant

In 2012, CMS launched the Adult Medicaid Quality Grant Program: Measuring and Improving the Quality of Care in Medicaid. This two-year grant program is designed to support state Medicaid agencies in developing staff capacity to collect, report, and analyze data on the Initial Core of Set of Health Care Quality Measures for Adults Enrolled in Medicaid (Initial Core Set). The three main goals of this grant are:

1. Testing and evaluating methods for collection and reporting of the Initial Core Set of Health Care Quality Measures for Adults Enrolled in Medicaid in varying delivery care settings.

2. Developing staff capacity to report the data, analyze, and use the data for monitoring and improving access and the quality of care in Medicaid.

3. Conducting at least two Medicaid quality improvement projects related to Initial Core Set Measures. Since several of the Initial Core Set Measures align with other CMS and federal quality improvement initiatives (e.g., the National Quality

Strategy, Strong Start Initiative, Partnership for Patients, and Million Hearts Initiative).

HHSC is working closely with MCOs, the state's EQRO and other contracted resources on implementation of specific quality improvement projects focused on improving behavioral healthcare and promoting improved birth outcomes. HHSC is also working on development of the data collection and reporting infrastructure.

Texas Institute of Healthcare Quality and Efficiency

Appointed by the Governor, the board of the Texas Institute of Healthcare Quality and Efficiency has a wide scope, encompassing the broader health care system in Texas, including Medicaid and CHIP. The Institute is charged with making legislative recommendations in three key areas:

- improving quality and efficiency of health care delivery;
- improving reporting, consolidation, and transparency of health care information; and
- implementing and supporting innovative health care collaborative payment and delivery systems.

MCO Report Cards

S.B. 7, 82nd Legislature, First Called Session, 2011, requires Medicaid members receive quality information on MCOs before they select an MCO. HHSC plans to publish MCO report cards online in 2014 showing how STAR, STAR+PLUS and CHIP health plans in each service area compare on health care quality. The report cards will be shared with the health plans prior to the publication online. Ultimately the reports cards will be included in health plans enrollment packets, to assist individuals in making health plan choices.

The Texas Health Learning Collaborative (THLC) Portal

The THLC portal is a secure web portal developed for use for HHSC and its Medicaid providers to give up-to-date reporting on MCO performance on key quality care measures, including potentially preventable events (PPEs) such as potentially preventable admissions, readmissions, emergency department visits, and complications. The interface includes many interactive maps, charts and figures allowing users to drill-down through metrics based on millions of Medicaid claims records, customizing the views and reports by time period, service type, line of business, area, etc.

First Dental Home Initiative

First Dental Home is an initiative designed to establish a Dental Home, provide preventive care, identify oral health problems, and provide treatment and parental/guardian oral health instructions as early as possible. Texas Medicaid defines a Main Dental Home as the dental provider who supports an ongoing relationship with the client that includes all aspects of oral health care delivered in a comprehensive,

continuously accessible, coordinated, and family-centered way.

The Dental Home provider is responsible for providing routine preventive, diagnostic, urgent, therapeutic, initial, and primary care to patients, maintaining the continuity of patient care, and initiating referral for care. Provider types that can serve as Main Dental Home Providers are general dentist and pediatric dentist. Main Dental Home providers must provide children enrolled in Medicaid (birth through age 20) with preventive services in accordance with the Texas Health Steps dental periodicity schedule.

The Medicaid and CHIP Quality-Based Payment Advisory Committee (QBPAC)

The Medicaid and CHIP QBPAC was created by S.B. 7, 82nd Legislature, First Called Session, 2011, and its members were appointed by the HHSC Executive Commissioner. Their charge is to make recommendations to HHSC regarding quality standards and benchmarks, regarding measures and metrics to measure quality, and policies and reimbursement systems that reward the provision of high-quality, cost-effective health care.

The QBPAC held quarterly meetings beginning on February 29, 2012. The committee initially conducted an assessment of Medicaid/CHIP medical costs, and the populations and/or services that comprised the high cost areas. Based on that information, the committee formed three subcommittees whose areas of focus were:

- HMO Payment Structures
- Payment Models for Pregnant Women and Children Populations
- Payment Models for Aged and/or Disabled Populations

The initial QBPAC recommendations are listed below. These recommendations are focused on areas of opportunity in managed care, and to a lesser extent, in the fee-for-service model. The recommendations are broad, to allow HHSC the flexibility in how to implement, if they chose to adopt. In making their recommendations, the committee is cognizant of the potential short- and long-term resource needs and fiscal impacts of some of the recommendations, both in terms of potential state costs to implement, as well as potential cost avoidance/savings to the state. Additionally, the committee is cognizant that some of the recommendations have associated risks.

- Change the State's premium payment processes, including risk adjustment, to promote investment by the HMOs in more innovative provider care models, such as shared savings or integrated care capitation, that achieve cost savings and improve the quality of care.
- Promote through the HMOs, provider payment models that better align incentives between provider and payer to achieve cost savings and improve the quality of care.
- Develop auto-assignment processes to incentivize plans to improve quality across the three categories of performance: administrative performance, clinical quality, and network adequacy. These encompass a number of indicators such as cost, HEDIS or other quality measure rates, and actual to expected rates of PPEs. If an HMO meets

targeted standards of quality and/or cost performance, or shows significant improvement across specific measures, then HHSC should recognize this effort by auto-assigning a proportionally larger number of default enrollees to that plan.

The full QBPAC report is found in Appendix B. Each recommendation in the report includes a rationale for its selection, as well as a brief list of potential issues, and measures and methodology for evaluating. In addition to the broad recommendations from the subcommittees, there are other recommendations related to processes or changes that could help support implementation of the broader recommendations.

Potential Future Path for HHSC Regarding Quality

S.B. 7 and S.B. 58, 83rd Legislature, Regular Session, 2013, require mental health and long- term services and supports populations and services be transitioned into a managed care system, thus moving the Medicaid/CHIP service delivery system to an almost exclusively MCO-managed care model. Additionally, S.B. 7 includes numerous provisions that are designed to promote quality and efficiency. S.B. 8, 83rd Legislature, Regular Session, 2013, directs HHSC to establish data analytical processes to improve contract management, detect data trends, and identify anomalies in service utilization, payment methodologies, and adherence to requirements in Medicaid and CHIP managed care and fee-for-service contracts. HHSC has begun developing implementation plans for these bills. These bills will take effect September 1, 2013.

There are provisions in these bills that are important components of a comprehensive approach for promoting quality and efficiency. Some of these provisions also align with the QBPAC's recommendations outlined in their report. The Committee will continue to meet on an ongoing basis and is available as a resource to HHSC to provide further details on its recommendations. It will continue to study additional programs and reimbursement policies that encourage high-quality, cost-effective health care delivery models.

APPENDICES

Appendix A: List of Quality Measures Used by HHSC and EQRO

Measures	Currently Captured for Managed Care	Currently Captured for FFS
Adult Inpatient Admission Rate (per 100,000)		
Diabetes with short term complications	X	
Diabetes with long term complications	X	
Chronic Obstructive Pulmonary Disease	X	
Hypertension	X	
Congestive Heart Failure	X	
Low Birth Weight (per 100)	X	
Dehydration	X	
Angina without Procedure	X	
Perforated Appendix	X	
Bacterial Pneumonia	X	
Urinary Tract Infection	X	
Uncontrolled Diabetes	X	
Adult Asthma	X	
Lower Extremity Amputation in Diabetes Patients	X	
Pediatric Inpatient Admission Rate (per 100,000)		
Asthma	X	
Diabetes Short Term Complications	X	
Gastroenteritis	X	
Urinary Tract Infection	X	
Perforated Appendix (per 100)	X	
Inpatient Utilization (average length of stay, days per 1,000 member months, discharges per 1,000 member month)		
By age groups and reason		
Adult ER utilization (per 1,000 member months)		
By age groups	X	
Pediatric ER utilization (per 1,000 member months)		
By age groups	X	
Potentially Preventable Events		
All Cause Potentially Preventable Emergency Room (PPV) Visits Rate	X	
All Cause Potentially Preventable Hospital Admissions (PPA) Rate	X	
All Cause Potentially Preventable Re-Admissions (PPR) Rate	X	X
Condition Specific Potentially Preventable Emergency Room (PPV) Visits Rate	X	
Condition Specific Potentially Preventable Hospital Admissions (PPA) Rate	X	
Condition Specific Potentially Preventable Re-Admissions (PPR) Rate	X	
Potentially Preventable Complications (PPC)	X	X
Potentially Preventable Ancillary Services (PPS)	future	
Outpatient Utilization (per 1,000 member months)		

By age groups	X	
Other Measures		
Avoidance of Antibiotic Treatment for acute bronchitis (18-64)	X	
Use of Appropriate Medications for persons with asthma (by age groups)	X	
Comprehensive Diabetes Care-HbA1c testing	X	
Comprehensive Diabetes Care-Eye Exams	X	
Comprehensive Diabetes Care-LDL-C screening	X	
Comprehensive Diabetes Care-diabetic nephropathy	X	
Appropriate Testing for Pharyngitis	X	
Appropriate Treatment for Upper Respiratory Infection	X	
Low Complication Cesarean Section Rate (per 100 births)	Possible Future	
NICU Utilization for non-Low Birth Weight Infants	Possible Future	
Well Child Visits >=6 within 15 months	X	
Well Child Visits 3rd, 4th, 5th and 6th years of life >=1 visit	X	
Adolescent Well Child Visits >=1 visit	X	
Prenatal Care	X	
Frequency of Prenatal Care (% of enrollees who had >80% of expected visits)	X	
Postpartum Care	X	
Access to Preventative/Ambulatory Services by age groups	X	
Access to PCP by age groups	X	
Cervical Cancer Screening	X	
Chlamydia Screening- by age group	X	
Breast Cancer Screening	X	
Childhood Immunization Status	X	
Adult BMI Assessment	X	
High blood pressure controlled	X	
Follow up Care for Children Prescribed ADHD medication-Initiation phase	X	
Follow up Care for Children Prescribed ADHD medication - Continuation/Maintenance phase	X	
Antidepressant medication management-Effective Acute Phase	X	
Antidepressant medication management -Effective Continuation Phase	X	
7 day follow up after hospitalization for mental illness	X	
30 day follow up after hospitalization for mental illness	X	
Mental Health Services Utilization by age group and service level	X	
Substance Use Disorder Services Utilization by age group and service level	X	
Enrollee Complaints per 1,000 member months	X	
Enrollee Appeals of Adverse Determinations per 1,000 member months	X	
MCO customer service and hotline hold time and abandonment rates	X	
Consumer Assessment of Healthcare Providers and Systems (CAHPS)	X	
Provider Network Access	X	
Relative Resource Use for People with Diabetes	future	
Relative Resource Use for People with Cardiovascular Conditions	future	

Relative Resource Use for People with Hypertension	future	
Relative Resource Use for People with COPD	future	
Relative Resource Use for People with Asthma	future	
Dental Quality Measures		
Dental Check ups	X	
Annual dental visits	X	
Dental Preventative services	X	
Dental Home services	X	
Dental Diagnostic Services	X	
Dental Sealants	X	
Long Term Services and Supports Measures		
Under development	future	

Definitions:

POTENTIALLY PREVENTABLE EVENTS (PPE)

Potentially Preventable Event (PPE) is a term that encompasses Potentially Preventable Emergency Room Visits (PPV), Potentially Preventable Admissions (PPA), Potentially Preventable Re-admissions (PPR), Potentially Preventable Complications (PPC), and Potentially Preventable Ancillary Services (PPS). Each PPE is defined below:

- Potentially Preventable Emergency Room Visits (PPVs)

PPV means treatment of a person in a hospital emergency room or freestanding emergency medical care facility for a condition that may not require emergency medical attention because the condition could be, or could have been, treated or prevented by a physician or other health care provider in a nonemergency setting.

- Potentially Preventable Admissions (PPAs)

PPA means an admission of a person to a hospital or long-term care facility that may have reasonably been prevented with adequate access to ambulatory care or health care coordination.

- Potentially Preventable Re-admissions (PPRs)

PPR means a return hospitalization of a person within a period specified by the commission that may have resulted from deficiencies in the care or treatment provided to the person during a previous hospital stay or from deficiencies in post-hospital discharge follow-up. The term does not include a hospital readmission necessitated by the occurrence of unrelated events after the discharge. The term includes the readmission of a person to a hospital for: (A) the same condition or procedure for which the person was previously admitted; (B) an infection or other complication resulting from care previously provided; or (C) a condition or procedure that indicates that a surgical intervention performed during a previous

admission was unsuccessful in achieving the anticipated outcome.

- Potentially Preventable Complications (PPCs)

PPC means a harmful event or negative outcome with respect to a person, including an infection or surgical complication, that: (A) occurs after the person's admission to a hospital or long-term care facility; and (B) may have resulted from the care, lack of care, or treatment provided during the hospital or long-term care facility stay, rather than from a natural progression of an underlying disease

- Potentially Preventable Ancillary Services (PPSs)

PPS means a health care service provided or ordered by a physician or other health care provider to supplement or support the evaluation or treatment of a patient, including a diagnostic test, laboratory test, therapy service, or radiology service, that may not be reasonably necessary for the provision of quality health care or treatment.

HEDIS RELATIVE RESOURCE USE (RRU) MEASURES

RRU measures are standardized ways to examine health care service cost and use for chronic conditions that also have associated HEDIS effectiveness measures. The goal for the state, health plans, and providers is to provide high quality and cost effective care. HEDIS RRU measures include the following:

- RDI- Relative Resource Use for People with Diabetes
- RCA – Relative Resource Use for People with Cardiovascular Conditions
- RHY – Relative Resource Use for People with Hypertension
- RCO- Relative Resource Use for People with COPD
- RAS – Relative Resource Use for People with Asthma

Select Quality Website Links

NCQA (HEDIS) website: http://www.ncqa.org/

AHRQ website: http://www.ahrq.gov/

NQF website: http://www.qualityforum.org/Home.aspx

Appendix B: Quality-Based Payment Advisory Committee Report

Executive Summary

The Medicaid and CHIP Quality-Based Payment Advisory Committee (QBPAC) was created by Senate Bill (S.B.) 7, 82nd Legislature, First Called Session, 2011, and its members were appointed by the HHSC Executive Commissioner. Their charge is to make recommendations to HHSC regarding quality standards and benchmarks, regarding measures and metrics to measure quality, and policies and reimbursement systems that reward the provision of high-quality, cost-effective health care.

The QBPAC viewed its charge through the prism of diminishing opportunities to effect change in the traditional fee-for-service model, due to the managed care expansion though the health plan model. The QBPAC also approached its charge with an initial assessment of Medicaid/CHIP medical costs, and which populations and/or services comprise high cost areas. From that information, they approached their work by categorizing it into subcommittees/areas of focus. These subcommittee/areas of focus were 1) HMO Payment Structures, 2) Payment Models for Pregnant Women and Children Populations, and 3) Payment Models for Aged and/or Disabled Populations.

The initial recommendations by the QBPAC focused on areas of opportunity in managed care, and to a lesser extent, in the fee-for-service model. The recommendations listed in this report are broad, to allow HHSC the flexibility in how to implement, if they chose to adopt. Each recommendation has a rationale for its selection, as well as a brief list of potential issues, measures and methodology for evaluating. In addition to the broad recommendations from the subcommittees, there are other recommendations related to processes or changes that could help support implementation of the broader recommendations.

In making their recommendations, the committee is cognizant of the potential short- and long-term resource needs and fiscal impacts of some of the recommendations, both in terms of potential state costs to implement, as well as potential cost avoidance/savings to the state. Additionally, some of the recommendations have associated risks.

The committee is scheduled to meet regularly through calendar year 2013 to further develop recommendations, including recommendations on standards and benchmarks, and quality measures and metrics. This report is an update on their current recommendations.

I. Legislation

The Medicaid and CHIP Quality-Based Payment Advisory Committee (QBPAC) is authorized by *Section 1.12, S.B. 7, 82nd Legislature, First Called Session, 2011*. Its core

role is to advise the Health and Human Services Commission (HHSC) on establishing:

1. Reimbursement systems used to compensate physicians or other health care providers under those programs that reward the provision of high-quality, cost-effective health care and quality performance and quality of care outcomes with respect to health care services;
2. Standards and benchmarks for quality performance, quality of care outcomes, efficiency, and accountability by managed care organizations and physicians and other health care providers;
3. Programs and reimbursement policies that encourage high-quality, cost-effective health care delivery models that increase appropriate provider collaboration, promote wellness and prevention, and improve health outcomes; and
4. Outcome and process measures that promote the provision of efficient, quality health care and that can be used to implement quality-based payments for acute and long-term care services across all delivery models and payment systems.

II. Formation of the committee and committee makeup

S.B. 7 required the Executive Commissioner to appoint members to the committee and designate a chairperson. Per S.B. 7, committee membership must consist of physicians and other health-care providers, representatives of health-care facilities, representatives of managed care organizations (MCOs), and other stakeholders interested in health-care services provided in this state. Specifically, membership must include at least one of each of the following:

- An obstetrician/gynecologist.
- A pediatrician.
- An internal medicine or family practice physician.
- A geriatric medicine physician.
- A long-term care services provider.
- A consumer representative.
- A member of the Advisory Panel on Health Care-Associated Infections and Preventable Adverse Events (APHCAI-PAE).

Executive Commissioner Thomas M. Suehs appointed the following individuals to the committee:

- Chairperson Dr. Mary Dale Peterson, Chief Executive Officer (CEO) of Driscoll Children's Health Plan in Corpus Christi.
- Trey Berndt, the American Association of Retired Persons (AARP) Associate State Director for Advocacy in Austin.
- Dr. Jorge Blanco, the Medical Director of West Texas Maternal Fetal Medicine Center, LLC, in Odessa.
- Dr. Glenda Coleman, the MCO Medical Director of United HealthCare Community Health Plan and Evercare in Houston, serving both Medicaid and CHIP clients.

- Dr. Barry Lachman, the MCO Medical Director for Parkland Community Health Plan in Dallas.
- Susan Mellott, PhD, the CEO of Mellott & Associates in Houston, a health-care quality consulting firm and member of APHCAI-PAE.
- Dr. Tom Parker, the Medical Director of the Community Care Consortium, PLLC, in Austin.
- Dr. Hanoch Patt, Medical Director of Children's Cardiology Group in Austin.
- Dr. Robert Stephens, the President of Cornerstone Pediatrics in Seguin.
- Dr. John Thoppil, Director of Quality for Cedar Park Regional Hospital in Cedar Park.
- Dr. Ronald Walters, Associate VP for Medical Operations and Informatics at MD Anderson in Houston.
- Dr. Stephen Whitney, incoming president of the Texas Pediatric Society and Assistant Professor of Pediatrics and Professor of the Practice of Healthcare Management at the Baylor College of Medicine in Houston.
- Dr. Jonathan Williams, a practicing rural physician in Wichita Falls.
- Dr. Wm. Brendle Glomb, the Medicaid Medical Director serves as an ex-officio member.

III. Orientation of the committee and topics of external presentations

At the initial meeting for the QBPAC members were provided with an overview of Texas Medicaid as it was as of March 1, 2012. The majority of claims and individuals are now under managed care rather than a fee-for-service delivery model. This changes the approach the committee needs to take for reimbursement models, but does not change the need to identify quality health care standards and benchmarks which can be used in the development of reimbursement models which improve health outcomes while decreasing health care costs.

The Committee separated its work into three working subcommittees to develop the overall committee recommendations:

I. HMO Payment Structures
II. Payment Models for Pregnant Women and Children Populations
III. Payment Models for Aged and/or Disabled Populations

Over the four meetings of the full committee, and through conference calls and communications with the subcommittee members, information was presented in person or by documents in many areas, including:

- Policy and Legislative Changes, including available resource materials, initiatives born out of the last legislative session, and a discussion on how work of this committee can complement ongoing efforts within HHSC, by Kimberly Davis, HHSC Program Policy.

- Data Capabilities and Medicaid expenditure information, population groups, and services provided by Texas Medicaid, by Rick Allgeyer, HHSC Strategic Decision Support.
- Overview of the managed care expansion in Texas Medicaid, effective March 1, 2012 and the performance-based at risk capitation population, by Eugenia Andrews, HHSC Managed Care Operations.
- A briefing document on quality-based reimbursement models, with specific focus on quality measures, standards, and benchmarks used by private, state, or federal programs, prepared by The Litaker group.
- Information on current HHSC initiatives, a timeline of events on quality-related activities (e.g., changes in payment structures) occurring at HHSC, some specific delivery system reimbursement, and measures used to assess quality within Medicaid managed care, by Matthew Ferrara, HHSC Healthcare Quality Analytics, Research and Coordination Support.
- Overview of an integrated care demonstration proposal to align Medicaid and Medicare services to dual eligible clients by Ms. Claire Seagraves, HHSC, Medicaid/CHIP division.
- Overview of quality incentive programs for nursing homes and long-term care facilities in Texas by Jon Weizenbaum, Deputy Commissioner, Department of Aging and Disability Services (DADS).
- Overview of quality-based payment incentives used by both private and public sector purchasers of health insurance and health care services, focused on five topic areas: (1) the challenge of misaligned incentives; (2) creating incentives for quality; (3) quality-based incentive strategies used by states with Medicaid Managed Care Organizations (MMCO); (4) quality-based incentive strategies used by MMCOs with providers; and (5) considerations for quality-based incentive strategies and special populations, by Michael Bailit, President, Bailit Health Purchasing, LLC.
- Overview of the quality of care report, potentially preventable events, and other quality related activities as related to HHSC and managed care in Texas Medicaid, by Dr. Betsy Shenkman, Director, Institute for Child Health Policy (ICHP), University of Florida.
- Briefing paper on methodologies to decrease C-section deliveries in the United States with an overview of factors that influence delivery by C-section, payment equalization for C-section birth and vaginal deliveries in select state Medicaid programs, and the impact that hospital capacity may have on mode of delivery, by The Litaker Group.

The Committee began its work in late February 2012. The committee spent time learning which Medicaid populations were continuing to receive services under the fee-for-service delivery model, or were in the managed care delivery model as of March 1, 2012. It accepted the premise that managed care organizations can deliver better health care outcomes at a lower cost than can be achieved in a traditional pay for service system. While consideration was given to the diminishing fee for service population, the committee focused on addressing opportunities for improvement in managed care. A package of initial recommendations was approved at the September 17, 2012 meeting,

which the committee feels present an opportunity to accelerate quality and cost savings by aligning incentives more effectively, shifting populations and services currently carved out of managed care into managed care, and by removing administrative and process barriers that limit the managed care organizations' ability to initiate innovative quality-based, evidence- based alternative reimbursement systems for care delivery.

The discussions of the overall advisory committee and subcommittees have focused on the areas of greatest opportunity for quality improvement and cost savings within the Medicaid/CHIP programs, given the movement of most clients to managed care for most Medicaid-covered services. Significant emphasis was also placed on the operational issues that exist within the Medicaid program, and how these barriers may be addressed to enable an expansion of quality based payment structures within the Medicaid/CHIP programs.

The committee will be meeting on a regular basis through calendar year 2013, to further develop recommendations for HHSC.

IV. Committee Recommendations

Subcommittee I: Recommendations for Health Maintenance Organization (HMO) Payment Structures:

- **Final Committee Approved HMO Incentive Recommendation #1**

Change the State's premium payment processes, including risk adjustment, to promote investment by the HMOs in more innovative provider care models, such as shared savings or integrated care capitation, that achieve cost savings and improve the quality of care.

This recommendation includes three components:

1) Establishment of seed money from the State to the HMOs to develop innovative payment models. This could potentially be provided short term through a relaxation of the experience rebate provisions, to allow some portion of funds that would have gone to the experience rebate to the State to be used as startup funds pool for all SDAs to help invest in new payment models and/or state approved projects. Long term, the State could develop shared savings models in which a portion of achieved savings could be retained by the HMO.

Potential Issues/Measures/Methodology: Experience rebate funds availability, parameters for disbursement of funds for infrastructure development.

2) Establishment of a capitation rate setting process that risk adjusts more frequently and closer to the period for which the HMO is paid. This would more accurately reflect current risk factors of each HMO's membership.

Potential Issues/Measures/Methodology: Revision to risk adjustment methodology. Resources to calculate more frequently would need to be considered.

3) Establishment of an HMO capitation rate re-basing process that allows for shared savings based on dollar savings from premium year to premium year, measured on both cost savings and achievement of state approved quality metrics such as potentially preventable events (PPEs) by HMO. The intent is for the HMOs to pass a significant portion of these shared savings in the form of reimbursement incentives to providers who achieve agreed upon quality/cost performance levels.

Potential Issues/Measures/Methodology: Measure risk adjusted HMO per member per month costs from year to year, actual to expected PPE rates of HMO membership.

Rationale for Recommendation #1:
A significant barrier cited on a recently administered survey to the Medicaid/CHIP HMOs on their payment structures was the need for state investment in infrastructure to help promote initial HMO investment in more quality-based payment structures to providers. Those include, but are not limited to, incentives for providers whose quality measure rates are higher than their peers, shared savings programs, and integrated care models (ACO) or medical homes). Related to this was the need to develop mechanisms to incentivize and help sustain this shift over time. This potential area has two basic elements: 1) Seed money to help stand up more innovative HMO to Provider payment models, and 2) a restructure of the HMO capitation rate setting process to adjust for risk and promote savings.

HMO capitation rates are based on HMO medical cost experience and administrative costs, with a community rating calculation. The community rating is a cost containment strategy to ensure that the rating process within a service delivery area (SDA) is averaged among the participating plans. However, the SDA rate used as the foundation for the community rate is based on each HMO's previous allowable medical and administrative costs and total member months within the SDA from prior data. It does not necessarily reflect current costs or plan membership.

The community rating process "equalizes" the capitation rates for an SDA, and brings high and low outliers to an average rate before administrative, risk adjustment and inflation add-on calculations. However, rates are still largely based on HMO costs and savings. This effectively means that any savings achieved by HMOs are retained by the Texas Medicaid program within the next rate setting cycle, lowering subsequent capitation rates. Conversely, if HMOs in an SDA did not aggressively lower costs, the following year's premiums would include those higher costs. This approach may disincentivize HMOs to seek innovative ways to improve quality, maximize efficiency and achieve cost savings.

<u>The Current At-Risk and Quality Challenge Award Program</u>
The 5 percent At Risk and Quality Challenge Award program is a cost neutral penalty-reward program that places up to 5 percent of each HMO's premiums at risk, It is based

on a set of "at risk" administrative and quality measures. Failure by an HMO to achieve one or more of the "at risk" measures results in withholding a portion of the HMO's premium funds, up to five percent. The "at risk" funds across all HMOs are then combined and form the statewide quality challenge pool of funds. HMOs that achieve an established level of performance on the quality challenge measures are able to receive funds from the quality challenge fund pool. While this program does have the potential to better align incentives, it is dependent on some HMOs losing funds to create the incentive pool. Additionally, since the measures for the at risk and quality challenge programs are different, there may be circumstances in which an HMO gets penalized through the at risk component and then rewarded through the quality challenge. Depending on the measures selected to gauge performance, this structure may not be sufficient to accelerate quality improvements and efficiency.

The committee recommended that the potential incentive misalignments outlined above be addressed in three basic components, outlined in the recommendations above.

- **Final Committee Approved HMO Incentive Recommendation #2**

Promote through the HMOs, provider payment models that better align incentives between provider and payer to achieve cost savings and improve the quality of care.

Potential Issues/Measures/Methodology: Additional contractual language; Targets or requirements for plans by HMOs, level of quality-based payments relative to overall payments.

Rationale for Recommendation #2:
One of the primary goals of the Quality-Based Payment Advisory Committee is to recommend ways to reward the provision of high-quality, cost-effective health care, quality performance and quality of care outcomes. A review of health care research literature indicates that the normal fee for service, or payment for driven by volume of claims, is not the preferred payment model to achieve these aims. However, Medicaid HMOs (CHIP, STAR, STAR+PLUS) that responded to a recent payment structures survey indicated approximately eighty-six percent of claims dollars are paid through a the standard fee for service payment delivery model rather than through capitation, shared savings, episodes of care, bundled payment or any other delivery model that is structured to incentivize quality health outcomes.

Various barriers to increasing Quality-Based Payment Structures and moving away from a fee for service model were noted in the HMO survey responses. Those include the current rate setting process for HMOs, data infrastructure issues at both the provider and HMO level, increased complexity, and the need for startup funds to promote innovative reimbursement models.

- **Final Committee Approved HMO Incentive Recommendation #3**

HHSC should develop auto-assignment processes to incentivize plans to improve

quality across the three categories of performance: administrative performance, clinical quality, and network adequacy. These encompass a number of indicators such as cost, HEDIS or other quality measure rates, and actual to expected rates of potentially preventable events (PPE) including potentially preventable emergency department visits (PPV), potentially preventable hospital admissions (PPA), potentially preventable hospital re-admissions (PPR), potentially preventable complications (PPC), and potentially preventable ancillary services (PPS). If an HMO meets targeted standards of quality and/or cost performance, or shows significant improvement across specific measures, then HHSC should recognize this effort by auto-assigning a proportionally larger number of default enrollees to that plan.

Potential Issues/Measures/Methodology: Metrics associated with administrative performance, clinical quality, and network adequacy

Rationale for Recommendation #3:
Auto-assignment of new enrollees into high performing HMOs is a cost neutral or cost saving method by which HHSC could drive quality improvements and efficiencies. It is used by a number of other states and the algorithms vary depending on the state. This process may create additional financial rewards for high achievement of established performance.

The committee recognizes that this auto-assignment process may place some low-performing HMOs in jeopardy. However, if the intent is to incentivize quality outcomes, then that should be the focus.

Summary of HMO Recommendations

The above recommendations are linked to and complement each other. Doing one without the other diminishes the cumulative impact and in some cases makes individual items more difficult to make operational.

The committee is aware there are numerous operational considerations that would need to be made in the event HHSC adopts these recommendations. These range from workload issues, data analytics, questions around operationalizing in tandem with the current at risk and quality challenge award programs and or other initiatives, attribution issues vis-à-vis Regional Healthcare Partnerships'(RHP) quality plans, and coordination with other initiatives such as the Department of State Health Services (DSHS) preventable hospitalizations initiative.

Subcommittee II: <u>Recommendations for Payment Models for Pregnant Women and Children Populations:</u>

- **Final Committee Approved Child and Adult Care Recommendation #1**

Develop an equalized, cost neutral professional and facility reimbursement rate for

vaginal and C-Section deliveries.

Potential Issues/Measures/Methodology: Increase in the rate of vaginal deliveries. Consider publishing facility level or C-Section rates: Note AHRQ article on Public Reporting as a Quality Improvement Strategy:
http://www.ahrq.gov/clinic/tp/gapqistp.htm

Rationale for Recommendation #1
Cesarean Section (C-section) rates in many areas of Texas are high. There are many initiatives underway designed to address these high C-section rates. Although many factors contribute to the high rates (scheduling, obesity, prenatal care, etc), the committee feels equalizing reimbursement rates for the professional and facility vaginal and C-section delivery claims may help increase the vaginal delivery rate.

- **Final Committee Approved Child and Adult Care Recommendation #2**

Increase facility and professional reimbursement rates for VBAC deliveries

Potential Issues/Measures/Methodology: Percent increase in VBACs. Consider publishing facility level VBAC rates.

Note AHRQ article on Public Reporting as a Quality Improvement Strategy:
http://www.ahrq.gov/clinic/tp/gapqistp.htm

Rationale for Recommendation #2
Rates for vaginal birth after Cesarean Section (VBAC) are low nationally and in Texas. Although many factors contribute to the low rates such as professional liability and the capability of the delivering hospital to provide the necessary services, the committee feels increasing the facility and professional reimbursement rate for VBAC deliveries may help promote an increase in clinically appropriate VBACs.

- **Final Committee Approved Child and Adult Care Recommendation #3**

Incentivize a Maternity Medical Home Concept for the general pregnancy population

Potential Issues/Measures/Methodology: Percent increase in patients who receive 1st trimester care, percent increase in the use of antenatal steroids, percent decrease in the number of low birth weight births, percent decrease in premature and large for gestational age births, improved patient satisfaction.

Rationale for Recommendation #3
Improving birth outcomes is an important goal of both HHSC and DSHS, and is being addressed through a number of initiatives. To help further this important goal, the committee feels it is important to incentivize maternal medical homes. Enhanced reimbursement models could require care management or other elements. HMOs or the

State could enhance payments for medical home /patient centered care practices meeting any of a number of criteria including but not limited to National Center for Quality Assurance (NCQA) Medical Home certification, Bridges to Excellence recognition, or March of Dimes Centering project sites. Reimbursement could be an enhanced rate or a gain sharing model.

- **Final Committee Approved Child and Adult Care Recommendation #4**

Incentivize a Maternal Medical Home Concept, high risk pregnancies (Prenatal Diabetic Care).

Potential Issues/Measures/Methodology: Healthcare Effectiveness Data and Information Set (HEDIS) measures associated with diabetes, percent decrease in large for gestational age births, improved patient satisfaction, percent decrease in overall cost of care per patient across condition or all services/medications costs.

Rationale for Recommendation #4
This is similar to #3, but it targets pregnant women with, or who develop, diabetes. Reimbursement models could pay for an intensive program of outpatient management of the pregnant patient with diabetes prior to pregnancy (Pre-GDM) as well as pregnant patients that develop diabetes in pregnancy (GDM). The program could include reimbursement for nutritional counseling, diabetic education by certified diabetic educators, frequent blood sugar checks, and professional personnel to contact the patients at least weekly to reinforce the education and assist in coordination of their care. Care transition back to the woman's primary care provider after delivery would also be a component.

- **Final Committee Approved Child and Adult Care Recommendation #5**

Incentivize a Pediatric Medical Home model for general and complex populations.

Potential Issues/Measures/Methodology: Percent increase in Children's Health Insurance Program Reauthorization Act (CHIPRA) effectiveness of care measures, percent decrease in ER visit rates or inpatient admission rates for potentially preventable ambulatory sensitive conditions such as asthma, improved patient satisfaction, percent decrease in overall cost of care per patient across condition or all services/medications costs.

Rationale for Recommendation #5
Medical home models are showing promise as a cost effective approach to managing care for patients to achieve good clinical outcomes. Similar to recommendation #3, HMOs could enhance payments for certain criteria as well as developing gain-sharing models to reduce emergency room (ER) visits and inpatient admissions. Reimbursement could include bonus payments for maintaining primary care medical home status (PCMH).

- **Final Committee Approved Child and Adult Care Recommendation #6**

Incentivize a Medical Home Model or a registry model for adult patients with chronic disease

Potential Issues/Measures/Methodology: Percent increase in Adult Quality Measure effectiveness of care rates, percent decrease in ER visit rates or inpatient admission rates for potentially preventable ambulatory sensitive conditions such as asthma, improved patient satisfaction, percent decrease in overall cost of care per patient across condition or all services/medications costs.

Rationale for Recommendation #6
This is similar to above, but for adults with complex or chronic conditions. Similar to recommendation #3, HMOs could enhance payments for certain criteria as well as developing gain-sharing models to reduce emergency room (ER) visits and inpatient admissions. Reimbursement could include bonus payments for maintaining primary care medical home status (PCMH).

Subcommittee III: <u>Recommendations for Payment Models for Aged and/or Disabled Populations:</u>

- **Final Committee Approved Long Term Care Recommendation #1**

Incentivize nursing homes and community based programs to reduce potentially preventable emergency room visits and potentially preventable hospital admissions. Increase the availability of community based living options. HHSC should direct the Department of Aging and Disability Services to publish potentially preventable emergency department rates by nursing home facility.

Potential Issues/Measures/Methodology: Percent reduction in potentially preventable emergency room visits (Note AHRQ article on Public Reporting as a Quality Improvement Strategy: http://www.ahrq.gov/clinic/tp/gapqistp.htm)

Rationale for Recommendation #1
Services provided to populations who are aged and/or disabled represent a disproportionately high percentage of Medicaid costs. One area of focus is the high rates of emergency room usage and hospital admissions for persons who reside in nursing homes. The committee feels that many of these visits and admissions are avoidable with some changes in nursing facility reimbursement incentives and changes to in medical benefits within the nursing home setting.

Public reporting of quality metrics, including long term care provider quality, has been shown to have a positive impact on quality improvement. This indicates that simply making comparative data available and accessible can, by itself, drive improvements in long term care quality.

Additionally, the acuity of persons in nursing homes may be less than or the same as

those living in the community under the Community Based Alternative (CBA) waiver. Costs associated with CBA are significantly less than those for nursing home care, but funding is not sufficient to allow more people to remain in the community and avoid nursing home placement. Overall costs could be reduced if the CBA waiver could serve more people.

- **Final Committee Approved Long Term Care Recommendation #2**

Incentivize Care Innovation and Quality Improvements to Improve Hospital Discharge Care Coordination and Care Transitions

Potential Issues/Measures/Methodology: Percent reduction in potentially preventable hospital re-admissions; increase in the Adult Quality Measure rate for Care Transition Transition Record Transmitted to Health Care Professional.

Rationale for Recommendation #2
Transitions from hospitals to community providers and/or nursing homes are often uncoordinated. This often results in preventable re-admissions. The committee feels that meaningful incentives and care innovations are needed to support a more robust discharge process and to achieve improved healthcare outcomes and costs savings.

V. Specific Business Process Changes to Enable the Committee Recommendations to be realized more fully

The process changes listed below pertain to one or more of the recommendations above.

1. **Recommendation:** Discontinue managed care carve-outs for populations and services. This includes no longer allowing disabled children to opt out of managed care, and requiring the managed care plans to include mental health rehabilitation, Early Childhood Intervention (ECI) case management, and reimbursement to nursing homes, etc. Texas Medicaid moved to a managed care model because it not only is more cost-effective in terms of total costs, but also because health outcomes are better when there is provider accountability for care oversight (primary care providers) and personalized, targeted case management Medicaid recipients.

   Rationale: Services which remain carved out are hidden from the managed care organizations and primary care providers. Populations in full managed care models receive more coordinated services than those in a traditional Medicaid fee for service delivery model. Clients that remain in fee for service rather than moving to managed care cannot benefit from having an assigned primary care provider, care managers, or innovative reimbursement models that require an accountable healthcare provider for each person. Therefore, those populations are at a healthcare disadvantage.

2. **Recommendation:** Require the HMOs to manage all aspects of care, allowing the HMO to subcontract services such as dental or mental health. Discontinue the practice of separate management companies providing some, but not all, services.

   Rationale: Similar to above. This includes eliminating NorthSTAR BHO since the designated medical managed care plan cannot see that client's overall needs, yet is responsible for managing them.

3. **Recommendation:** Decrease, and eliminate where possible, the ability for members to change from one HMO to another without a clinical or geographic reason. Change should be allowed when the member moves out of area, or when the member's needs are not adequately being met by that plan. Change for non-clinical or geographic reasons should not be allowed because continuity of care management at the managed care plan level, especially for services over time such as behavioral health or dental, is compromised as members move in and out of plans. Note that change to a different provider should be allowed within plans.

   Rationale: This enables HMOs to more effectively manage care, and promote quality- based payment strategies for their providers and for the benefit of their membership. This is especially important for pregnant women show should stay with one plan for the total prenatal, delivery and postpartum period. Additionally, measurement of quality is improved.

4. **Recommendation:** Require immediate enrollment into managed care for all pregnant women who meet minimal enrollment criteria. See also # 6.

   Rationale: Lack of care management in a FFS model, and having to change providers, may cause essential pregnancy management services to be missed because the woman no longer meets the gestational age requirements once she finally is in a managed care plan. This also enables medical home models to occur. This allows for more effective and more prompt intervention and care coordination for high risk pregnancies.

5. **Recommendation:** Increase the eligibility segment length for children, pregnant women and CHIP Perinates.

   Rationale: This allows for better family planning care coordination post birth, with increased spacing between births. This reduces the likelihood of a premature or low birth weight baby. Extending the eligibility segment for children should enable more preventive care, and result in fewer children leaving Medicaid only to return with increased, avoidable complications.

6. **Recommendation:** Enroll newborns immediately into managed care using a pre-defined algorithm for assignment. Address the issue of mother and infant being enrolled in different plans.

Rationale: This allows for better care coordination. The managed care plans work directly with the hospitals and physicians on behalf of their neonates, with appropriate referrals to prior to discharge for follow up care. Keeping newborns in FFS until discharge, and then having them switch to managed care, presents a barrier for at risk babies to receive targeted care management and may hinder post discharge care.

7. **Recommendation:** Require the HMOs to process Medicare-submitted crossover claims for dual-eligible services, rather than those being processed by the claims administrator, or require the claims administrator to provide Medicare-submitted claims to the HMOs within 7 days of receipt of them.

   Rationale: The managed care plans are blind to services provided through Medicare, so they don't know their members are in the hospital, or receiving outpatient mental health services or therapies. This allows for better care coordination

8. **Recommendation:** Provide HMOs with 36 months of Medicaid and CHIP claims data for members enrolled in that HMO.

   Rationale: This allows for better care coordination by allow the HMOs to see a more complete clinical history of their enrollees. Currently no medical claims information is provided to a plan when a new member enrolls from either FFS or another plan. This makes it very difficult to see prior service patterns and provide care oversight.

9. **Recommendation:** Provide the HMOs with the enrollment start and end dates for members when assigned to the plan.

   Rationale: This facilitates better care coordination and continuity of care, by flagging estimated end dates of enrollment in Medicaid. Currently only a one month end date is provided, so plans and providers do not have an automated way to know how long the member will be eligible for services, thus making decisions on treatment requiring multiple visits over time difficult to schedule and may result in members receiving partial treatment which may be of little use. Examples include behavioral health counseling, physical therapy, and dental. An additional benefit would be to prompt HMOs to work with providers and enrollees to renew prior to the end date.

10. **Recommendation:** Reimburse for an initial high risk pregnancy assessment.

    Rationale: Identifies high risk pregnancies at the first visit, and thus starts the appropriate care management. This enables medical home models to occur. This allows for more effective and quicker care coordination for high risk pregnancies. This should result in reduced costs over time.

11. **Recommendation:** Add diabetic education as a benefit for all ages, including education specific to pregnant women, and add certified diabetic educators as performing providers for all ages.

    Rationale: This allows for more effective and quicker care coordination for high risk pregnancies, and for general populations. This enables better transition post\ delivery to appropriate providers,

12. **Recommendation:** Increase current funding for community-based living options under the DADS waivers, when their needs could be met at a lower cost and higher quality of life in the community.

    Rationale: Many individuals in nursing homes have the same level of disability as persons supported in the community. This allows for more cost effective alternatives to be utilized.

13. **Recommendation:** Add language to current rule to allow telemedicine and telehealth services in settings such as a nursing home, skilled nursing facility, or other setting, provided by ER physicians and other providers not at the patient site. This should reduce avoidable ER visits and hospital admissions, and provide ongoing care that does not require ambulance transport to another location.

    Rationale: This allows for more cost effective alternatives to be utilized, and avoids high costs of transport and ER use.

14. **Recommendation:** Add care oversight of residents in skilled nursing facilities (SNF) and nursing homes (NH) as a benefit, allowing mid-level providers as well as physicians to bill for that service.

    Rationale: This allows for more cost effective alternatives to be utilized and isn't reliant only on the physician provider population. Advanced Practice Nurse Practitioners (APRN) and Physician Assistants may be the member's PCP and should be allow to provide care wherever and whenever needed.

15. **Recommendation:** HHSC and DADS to collaborate on shared savings or other reimbursement incentive options for nursing homes.

    Rationale: This aligns incentives for nursing homes to achieve reduced overall care costs and quality improvements

16. **Recommendation:** Work with private carriers and our managed care plans to create billing and payment options for care models other than fee for service.

    Rationale: This helps move the healthcare system forward toward a more quality-based approach to providing services, rather than paying for service volume

17. **Recommendation:** Set certain common elements for provider report cards, and consider standardizing provider report card information across all plans in which the provider participates.

    Rationale: This helps move the healthcare system forward toward a more quality-based approach, while reducing health plan administrative complexities and increasing quality information to providers.

18. **Recommendation:** HHSC should consult with the HMOs and assess options for improving and consolidating processes that could reduce the administrative burdens on the HMOs and /or the providers.

    Rationale: This helps move the healthcare system forward toward a more quality-based approach, while reducing administrative complexities

19. **Recommendation:** Develop new plan funding approaches which better incentivize plans for care coordination and management, other than the current Quality Challenge and At Risk models which may serve as a disincentive to reducing costs while increasing quality healthcare outcomes.

    Rationale: This helps move the healthcare system forward toward a more cost effective and quality-based approach..

20. **Recommendation:** Legislation should provide clear direction on whether Medicaid service rule changes, including those pertaining to cost containment, rates and benefits, apply to only managed care, fee for service, or to both managed care and fee for service delivery models.

    Rationale: To reduce confusion at the state HMO and provider level on the impact of legislation, and to ensure changes affect that population best served by them.

21. **Recommendation:** Develop a funded, dedicated Texas Health and Human Services (HHS) data group, or contract with an external group to develop outcomes and trend analyses, and provide timely feedback to relevant stakeholders.

    Rationale: This helps move the healthcare system forward toward a more empirical, systematic quality-based approach.

22. **Recommendation:** Identify and remove statutory restrictions on data sharing, where possible.

    Rationale: This allows for more effective and quicker care coordination and reduces cost. There is much data that currently cannot be shared across programs and agencies which could be used well to identify opportunities for improvement and reduce waste.

V. Issues under Consideration

The following are some additional topics still being discussed by the Committee:

- Explore obesity-related services as benefits. This might include but not be limited to changes to the current limited nutritional counseling benefit and addition of registered dieticians as providers. Further research is needed to determine if these changes would benefit our long term health care goals.

- Limit each service delivery area (SDA) to two managed care plans. The intent is to change current practice which allows plans with fewer than 30,000 members, adds to providers' administrative burden in areas where multiple plans are in place, adds to the potential for plans to be forced into higher cost contracts with providers to compete with an adequate network, and requires the addition of any health district plan regardless of need.

VI. Future Committee Activities

The Committee will continue to meet on an ongoing basis and is available as a resource to HHSC to provide further details on committee recommendations. It will continue to study additional programs and reimbursement policies that encourage high-quality, cost-effective health care delivery models.

S.B. 7 directs the Committee to also address the following tasks which will be the focus in calendar year 2013. The committee is responsible for advising on or making recommendations for:

- The development of quality-based outcome and process measures that promote the provision of efficient, quality health care and that can be used in the child health plan and Medicaid programs to implement quality-based payments for acute and long-term care services across all delivery models and payment systems, including fee-for-service and managed care payment system

- The development of quality of care and cost-efficiency benchmarks, including benchmarks based on a managed care organization's performance with respect to reducing potentially preventable events and containing the growth rate of health care costs.

- The development of guidelines establishing procedures for providing notice and information to, and receiving input from, managed care organizations, health care providers, including physicians and experts in the various medical specialty fields,

and other stakeholders, as appropriate, for purposes of developing and establishing the quality-based payment and reimbursement systems and initiatives

- The development of payment initiatives to test the effectiveness of quality-based payment systems, alternative payment methodologies, and high-quality, cost-effective health care delivery models that provide incentives to physicians and other health care providers to develop health care interventions for child health plan program enrollees or Medicaid recipients, or both

- The development of quality-based payment systems for compensating a physician or other health care provider participating in the child health plan or Medicaid program that:
  (1) align payment incentives with high-quality, cost-effective health care;
  (2) reward the use of evidence-based best practices;
  (3) promote the coordination of health care;
  (4) encourage appropriate physician and other health care provider collaboration;
  (5) promote effective health care delivery models; and
  (6) take into account the specific needs of the child health plan program enrollee and Medicaid recipient populations.

- The development of reimbursement systems which base a percentage of the premiums paid to a managed care organization on the organization's performance with respect to outcome and process measures developed under Section 536.003, including outcome measures addressing potentially preventable events.

- The development of adjustment to child health plan and Medicaid reimbursements to hospitals, including payments made under the disproportionate share hospitals and upper payment limit supplemental payment programs, in a manner that may reward or penalize a hospital based on the hospital 's performance with respect to exceeding, or failing to achieve, outcome and process measures developed under Section 536.003 that address the rates of potentially preventable readmissions and potentially preventable complications.